MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Pharmacy Management Corporation P.O. Box 15640 Fort Worth, TX 76119-5640	MDR Tracking No.: M4-03-6594-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Charter Oak Fire Insurance Co. Box 05	Date of Injury: Employer's Name: Insurance Carrier's No.: 039CBAYE4978

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
05/23/02	**05/23/02**	**Carisoprodol 350 mg., #60**	**$118.73**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 06/04/03 states in part, "…The disputed issue is that the Carrier originally paid $47.36 stating "F" reimbursed according to the Texas Fee Guidelines. We resubmitted the claim to the Carrier requesting additional payment. The Carrier then paid $43.37 stating through a review of original payment and additional information received, it has been determined original invoice was process incorrectly which resulted in this additional payment. We resubmitted the claim again as the claim was still not paid within the guidelines…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary from the respondent was not submitted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

NCD Code for Carisprodol, 350 mg, #60: 00143117605, as described on the TWCC-66a for date of service 05/23/02 with PEC "F". The *Price Alert* of May 15, 2002 lists carisoprodol for the NCD number referenced as $289.10 per 500 each. Per the formula (AWP)/unit x number of units x $1.38 + $7.50 = MAR in the 1996 Medical Fee Guideline, Pharmaceutical Ground Rule (II)(A)(2) additional reimbursement is not recommended.

$289.10 ÷ 500 = .5782 x 60 = $34.80 x $1.38 = $48.92

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
5/23/2002	143117605	$118.73	$0.00				
				Total Left Column:			$118.73
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	01-13-05

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____